

Acknowledgement of Notice of Privacy Practices

The law requires that Family Vision Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

(Check one)

- I have read or had explained to me Family Vision Center's Notice of Privacy Practices and agree to continue my care with Family Vision Center under said terms.
- I was given an opportunity to read Family Vision Center's Notice of privacy Practices and decline but wish to continue my care with Family Vision Center under the terms of Family Vision Center's privacy policies.
- I have read or had explained to me Family vision Center's Notice of Privacy Practice and do not wish to continue my care with Family Vision Center under said terms.
- The Notice of Privacy Practice could not be read to the emergent nature of the care of other reason described as

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient

Date

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative

Relationship to Patient